Resident's Name:_____**Rm/Apt #**_____

Date of Review (M/D/Y)_____

Assisted Living Resident Needs Assessment

Pre Move-In ☐ ***Change in Condition*** ☐ ***Annual Category A*** ☐ ***Quarterly B*** ☐ ***Quarterly C*** ☐
Initial 60 day (if applicable) ☐

Resident's Name:_____

Resident's Age:_____***Gender:***_____***Marital Status:***_____ ***Move-in Date:***_____

Completed By:_____ ***Title:***_____

Date of Review (M/D/Y)_____

* *Indicates* ***Potential*** *for further assessment and changes to plan of care*
** *Indicates* ***Automatic assessment*** *and* ***change in plan of care***
ß *Indicates Category B criteria*
Ç *Indicates* ***Possible*** *Severe Cognitive Impairment criteria*

SECTION I. COGNITIVE PATTERNS (NOT AN ADL by Definition, 50-5-101 (3) MCA)

Short-term Memory
☐ 0. Resident can recall items after 5 minutes.
☐ 1. Resident cannot recall items after 5 minutes. **** or Ç***

Long-term Memory
☐ 0. Resident can recall events long past
☐ 1. Resident cannot recall events long past. **** or Ç***

Memory recall Check all that resident is **able** to recall
(Fewer than 3 indicates memory problem ***Ç***)
☐ Current season
☐ Location of room
☐ Awareness of home
☐ Caregivers names/faces

Decision Making
☐ 0. Independent: makes consistent, independent decisions
☐ 1. Modified independence: difficulty in new situations. *
☐ 2. Moderately impaired: needs cueing for directions. **** or Ç***
☐ 3. Severely impaired: rarely/never makes decisions. ***Ç***

Change in cognitive status/awareness or thinking disorders

☐ 0. No change in cognitive status.
☐ 1. Less alert, easily distracted, lethargic. * ***or Ç***
☐ 2. New episodes of incoherent speech. **** or Ç***
☐ 3. Restless, agitated, pacing. ***Ç ****

SECTION II. SENSORY PATTERNS (NOT AN ADL by Definition, 50-5-101 (3) MCA)

Hearing

☐ 0. Hears adequately: normal talk, TV, phone without difficulty
☐ 1. Minimal loss: difficulty only with noisy backgrounds.
☐ 2. Moderate loss: cannot hear unless spoken to distinctly and directly.
☐ 3. Severe loss: total loss of useful hearing. *
- ☐ Hearing aid: present and used
- ☐ Hearing aid: present but not used
- ☐ Hearing aid: not present

Speech: Ability to understand others

☐ 0. Understands others without difficulty or error.
☐ 1. Usually understands: occasionally misses part of message.
☐ 2. Sometimes understands: responds appropriately to simple direction. * ***or Ç***
☐ 3. Rarely/Never understands. ***Ç***

Speech: Ability to make self understood

☐ 0. Speech is easily understood by others.
☐ 1. Speech usually understood: has difficulty finishing thought, finding words. *
☐ 2. Speech sometimes is understood: can make simple requests. *
☐ 3. Speech is rarely/Never understood. * ***or Ç***

Vision: Ability to see in adequate light (with glasses, contacts, etc.)

☐ 0. Sees fine detail: can read regular print.
☐ 1. Mildly Impaired: requires large print, uses magnifying glass.
☐ 2. Moderately Impaired: cannot read newspaper headlines.
☐ 3. Severely Impaired: sees only light/shadow/shapes/colors. *
☐ 4. Peripheral vision problem
(bumps into people, objects, leaves food on side of tray). *

SECTION III. CONTINENCE (NOT AN ADL by Definition, 50-5-101 (3) MCA)

Bladder continence:

(resident has control over bladder function; Resident can participate in continence program)

☐ 0. Continent: resident has complete control over bladder function.
☐ 1. Usually continent: 1 episode/week or less of incontinence.
☐ 2. Occasionally incontinent: 2 or more episodes/week (not daily)
☐ 3. Frequently incontinent: some control present (day shift) but has some episodes daily.*
☐ 4. Incontinent: multiple daily episodes, no control present.*
☐ 5. Urinary tract infection. *
- ☐ Resident has not been treated for urinary tract infections
- ☐ Resident has been treated for urinary tract infections.

Bowel continence: (control of bowel movement)
☐ 0. Continent: resident has complete control over bowel function.
☐ 1. Usually continent: less than 1 episode of incontinence/week.
☐ 2. Occasionally incontinent: 1 episodes/week.
☐ 3. Frequently incontinent: 2-3 episodes of incontinence/week. *
☐ 4. Incontinent: inadequate control most or all of the time. *

Continent appliance/programs (Check all that apply)
☐ Scheduled toileting plan
☐ External catheter (condom)
☐ Pads/Briefs used
☐ Intermittent catheter
☐ Indwelling catheter

CHANGE IN CONTINENCE SINCE LAST ASSESSMENT
☐ 0. No change or improved.
☐ 1. Deteriorated: more episodes of incontinence. *

SECTION IV. MOOD AND BEHAVIORAL PATTERNS

THESE MAY ALL BE SIGNS AND SYMPTOMS OF SEVERE COGNITIVE IMPAIRMENT

Sadness or Anxiety Displayed by Resident: Sadness/anxiety does not alter
(Check all that apply)
☐ None: resident does not display or verbalize sadness.
☐ Resident verbally expresses hopelessness, grief, fears.**
☐ Resident is tearful: sighing, breathless without activity.**
☐ Resident is pacing: wringing hands, picking at clothes.**
☐ Resident withdraws from self-care, does not eat.**
(refuses medications.**)
☐ Resident expresses concern about imminent death.**
☐ Resident expresses suicidal thoughts or plan of action.**

Wandering: no rational purpose to movement;
Resident is oblivious to safety
☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior occurs less than daily.**
☐ 2. Behavior occurs daily or more.**

Verbally abusive: screaming, cursing, threatening others
☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior occurs less than daily.**
☐ 2. Behavior occurs daily or more.**

Physically abusive: hitting, shoving, scratching others
☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior occurs less than daily.**
☐ 2. Behavior occurs daily or more.**

Socially inappropriate/Disruptive behavior: self-abusive acts
(disrobing in public, throwing food, smearing feces, sexual behavior
☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior occurs less than daily.**
☐ 2. Behavior occurs daily or more.**

Resistant behavior:
☐ 0. No resistant behavior displayed.
☐ 1. Resistant to taking medications/resisted ADL assistance.*

SECTION V. HEALTH PROBLEMS/ACCIDENTS (Check all that apply)

☐ Constipation
☐ Dizziness
☐ Hallucinations*
☐ Shortness of breath*
☐ Aspiration/Choking*
☐ Diarrhea*
☐ Fainting
☐ Pain
☐ Nausea
☐ Falls without injury**
☐ Fecal impaction*
☐ Fever
☐ Joint aches
☐ Vomiting*
☐ Falls with injury**
☐
☐
☐
☐

SECTION VI. WEIGHT/NUTRITIONAL STATUS (Weight must be measured consistently)

Move-in date: **Weight upon move-in**: **Weight at last assessment:**
Current weight in pounds ***Scale used***

☐ 0. Weight unchanged: less than 3-5 lb. No change in past 30 days.
☐ 1. Weight gain of 5 lb. or more in 30 days.
☐ 2. Weight loss of 5lb. or more in 30 days.

Nutritional complaints (Check all that apply)
☐ Resident complains about the taste of foods.**
☐ Resident refuses most fluids at meals and snacks.**
☐ Resident complains of hunger frequently.**
☐ Resident leaves ¼ or more meal uneaten.**
☐ Resident has dentures/bridge and uses them.
☐ Resident has lost own teeth/does not use dentures.**
☐ Resident has broken, loose teeth with unfilled cavities.**

☐ Resident has swollen, bleeding gums.**

SECTION VII. SKIN PROBLEMS (Check all that apply)

☐ No history of skin problems/no current problems
☐ Resident has history of healed skin lesions/pressure sores
☐ Resident currently has open skin lesion or pressure sore.**

50-5-226. Placement in assisted living facilities. *(2) An assisted living facility licensed as* ***a category A facility*** *under* ***50-5-227*** *may not admit or retain a category A resident unless each of the following conditions is met: (b)* ***The resident may not have a stage 3 or stage 4 pressure ulcer****.*

SECTION VIII. MEDICATION USE (Check all that apply, may make notes/comments)

☐ Takes no prescription medicine.
☐ Takes prescription and OTC (over-the-counter) medication.
☐ Medications have changed/added in 30 days.*
☐ Currently taking an antibiotic (3-day, 7-day, 14-day).*
☐ Unable to self-administer medications. If Category A, what arrangements are made for medication administration?
☐ Unable to ask for PRN (as needed) medications. * ***ß or Ç***

Antipsychotic use
☐ None.
☐ Takes less than weekly.
☐ Takes 1-2 times/week.*
☐ Takes daily.* and/or ***Ç***
☐ Has PRN (as needed) ordered for behavioral control. * ***ß or Ç***

Antianxiety/Hypnotic use
☐ None.
☐ Takes less than weekly.
☐ Takes 1-2 times/week.*
☐ Takes daily.* and/or ***Ç***
☐ Has PRN (as needed) ordered for behavioral control. * and/or ***Ç***

Antidepressant use
☐ None.
☐ Takes less than weekly.
☐ Takes 1-2 times/week.*
☐ Takes daily.* and/or ***Ç***

SECTION IX. SAFETY/ASSISTIVE DEVICES USED (Check all that apply)

☐ None.
☐ Lap pillow to prevent rising: used less than daily.*
☐ Lap pillow/safety belt: used daily.*
☐ Cane. ☐ Wheelchair. ☐ ½ bed rails. ☐ Bed alarm. ☐ Chair alarm.
☐ ***OTHER:***

50-5-226. Placement in assisted living facilities. (2) An assisted living facility licensed as a category A… (a) The resident **may not require physical or chemical restraint or confinement in locked quarters**, but may consent to the use of safety devices pursuant to Title 50, chapter 5, part 12.
(Additional information and forms are located at:
http://www.dphhs.mt.gov/programsservices/safetydevice/index.shtml

SECTION X. ACTIVITIES OF DAILY LIVING (ADL) FUNCTIONAL PERFORMANCE
(As defined in 50-5-101 (3) MCA***)***

Eating: (how resident eats and drinks)
☐ 0. Independent: needs no help or supervision.
☐ 1. Needs supervision: often needs encouragement, cueing.
☐ 2. Limited assistance: needs some physical help and support.
☐ 3. Extensive assistance: needs full staff support at most meals. * ***or Ç***
☐ **4. Total dependence:** resident needs to be fed. * ***ß or Ç***

Walking (Check all that apply)
☐ 0. None.
☐ 1. Cane/Walker.
☐ 2. Braces/Prosthesis.
☐ 3. Wheels self.
☐ **4. Total dependence:** Wheeled by others. ***ß or Ç***

Mobility: (how resident moves within room and home, includes self-sufficient use of mobility devices)
☐ 0. Independent: needs no help or supervision.
☐ 1. Needs supervision: often needs encouragement, cueing.
☐ 2. Limited assistance: needs some physical help and support.
☐ 3. Extensive assistance: needs full weight-bearing staff support. *
☐ **4. Total dependence:** always needs staff to perform locomotion. ***ß or Ç***

Dressing: (how resident puts on, fastens, takes off clothing; includes applying/removing prosthesis)
☐ 0. Independent: needs no help or supervision.
☐ 1. Needs supervision: often needs encouragement, cueing.
☐ 2. Limited assistance: needs some physical help and support.
☐ 3. Extensive assistance: needs full staff support to get dressed. * ***or Ç***

☐ **4. Total dependence:** staff needs to dress resident.* ***ß or Ç***

Grooming: (how resident combs hair, brushes teeth, shaves beard, cleans & cares for finger and toe nails, makeup, etc.)

☐ 0. Independent: needs no help or supervision.
☐ 1. Needs supervision: often needs encouragement, cueing.
☐ 2. Limited assistance: needs some physical help and support.
☐ 3. Extensive assistance: needs full staff support to groom. * ***or Ç***
☐ **4. Total dependence:** staff needs to groom resident.* ***ß or Ç***

Bathing: (how resident takes a full body bath/shower; includes transferring in/out of tub/shower; excludes washing back and hair)

☐ 0. Independent: no help provided.
☐ 1. Needs supervision: oversight help only.
☐ 2. Needs minimal assistance: only to transfer.
☐ 3. Needs moderate assistance: needs physical help in bathing.*
☐ **4. Total dependence:** staff must bathe resident. * ***ß or Ç***

Use of toilet: (includes how resident transfers on/off toilet/commode; cleanses self, changing protective garments/pads; adjusts own clothes)

☐ 0. Independent: needs no help or supervision.
☐ 1. Needs supervision: encouragement, reminding, oversight.
☐ 2. Limited assistance: needs some physical help transferring.
☐ 3. Extensive assistance: needs help transferring and toileting. * (cleansing, changing pads, adjusting clothes)
☐ **4. Total dependence:** staff fully toilets resident. ***ß or Ç***

Ability to transfer (to and from bed, chair, wheelchair-from laying, sitting, to standing)

☐ 0. Independent: needs no help or supervision.
☐ 1. Needs supervision: often needs encouragement, cueing.
☐ 2. Limited assistance: needs some physical help in maneuvering, minimal support.
☐ 3. Extensive assistance: needs full weight-bearing staff support. *
☐ **4. Total dependence:** always needs staff to perform transfer. ***ß or Ç***

CHANGE IN ADL FUNCTIONAL PERFORMANCE SINCE LAST ASSESSMENT

☐ 0. No change or improved.
☐ 1. Deteriorated in functional ability/performance. *

THE RESIDENT IS TOTALLY AND CONSISTENTLY DEPENDENT IN:

(# of ADLs As defined in 50-5-101 (3) MCA)

☐ ***Eating*** ☐ ***Walking*** ☐ ***Mobility*** ☐ ***Dressing***
☐***Grooming*** ☐ ***Bathing*** ☐ ***Toileting*** ☐ ***Transferring***

50-5-226 MCA Placement in assisted living facilities(2) An assisted living facility licensed as a category A facility under **50-5-227** may not admit or retain a category A resident unless…(f) The resident must be able to accomplish activities of daily living with supervision and assistance based on the following:

(i) **the resident may not be consistently and totally dependent in four or more activities of daily living** as a result of a cognitive or physical impairment; and

(ii) **the resident may not have a severe cognitive impairment that renders the resident incapable of expressing needs or making basic care decisions**

AREAS OF CHANGE AND/OR COMMENTS:

(Add additional pages as needed: # pages added are_____)

Doctor's or Dentist Appointment/s recommended & scheduled for:
(List below the Date, Time, Location and Name of Dentist/Physician or other Licensed Health Care Professional)

SECTION XI. **50-5-226 MCA. Placement in assisted living facilities.**
(3) An assisted living facility licensed as a category B facility under **50-5-227** **may not admit or retain** a category B resident unless each of the following conditions is met:

(a) The resident may require skilled nursing care or other services for more than 30 days for an incident, for more than 120 days a year that may be provided or arranged for by either the facility or the resident, and as provided for in the facility agreement.

(PLEASE DOCUMENT INCIDENTS FOR ONE YEAR BELOW)

Starting Date of Record:_____***Year ending on:***_____

Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
Resident required_____care beginning on: (date)	Ended on: (date)	Total Days:	
		TOTAL DAYS:	

(Add additional pages as needed: # pages added are_____)

SECTION XII. RESIDENT'S CATEGORY OF CARE & CARE NEEDS IDENTIFIED

Is there a change to the Resident's Service Plan Recommended: ☐ **YES** ☐ **NO**

Is there a Category Change: ☐ **YES** ☐ **NO**

If a Category change or significant change in condition, can the facility meet the needs of the resident?
☐ **YES** ☐ **NO**

Health Care Plan to be written: ☐ **YES** ☐ **NO If Yes, by (Date, M/D/Y):**_____
(Category A, if indicated, and all Category B and C Residents **within 21 days from completion of the date of this assessment by a licensed health care professional.)**

Change to Health Care Plan Recommended: ☐ **YES** ☐ **NO**
(Category A, if indicated, and Category B and C Residents who currently ***have*** a care plan developed by a licensed health care professional.)

Category B & C Requirement Review

1. Practitioner's written order for admission *received and in file:* ☐ **YES** ☐ **NO**

2. Signed quarterly health care assessment *by a licensed health care professional:* ☐ **YES** ☐ **NO**

3. ***Health care plan*** *developed, reviewed and/or revised by above professional:* ☐ **YES** ☐ **NO**

4. Signed quarterly certification *by a licensed health care professional that the resident needs can be adequately met by facility and there has been no significant health care status that would require another level of care :* ☐ **YES** ☐ **NO**

Assisted Living Resident Needs Assessment Summary

Based upon this assessment, the Category for this resident's level of care is:

☐ **A** ☐ **B** ☐ **C**

(For Category C residents: identify level of health care needs; A or B)

☐ ***Resident is a Hospice Patient:*** ☐ Care needs can be met ☐ Care needs **can not** be met

☐ ***Requires services and/or skilled professional care beyond the level of care/services available at this facility.***

☐ ***Requires services and/or skilled professional care beyond the level of assisted living care/services.***

Involuntary Discharge/Move out required? ☐ **YES** ☐ **NO**

If yes, Involuntary Discharge 30 day or emergent notice written: ☐ **YES** ☐ **NO**

*Assessor's Signature:*_____*Date:*_____

*Assessor's Title/Job position:*_____